Ontario Health atHome

COPD & Heart Failure Telehomecare Referral Form

Please fax referral forms(s) to:

If required, Telehomecare staff will fax the referral form to the Primary Care Provider to verify and/or add any relevant information.

PATIENT INFORMATION

Referral Date (DD MM YYYY): ____/____/______

LAST NAME	FIRST NAME		DATE OF BIRTH (DD MM YYYY)
HEALTH CARD NUMBER (OHIP)		VC	GENDER MALE FEMALE
ADDRESS		CITY	
POSTAL CODE	PRIMARY PHONE NUMBER		
FIRST LANGUAGE	SECOND LANGUAGE		

ELIGIBILITY FOR TELEHOMECARE SERVICES

- ☐ Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions).
- ☐ Patient lives in a residential setting with an active land line (internet or analog phone line).
- ☐ Health care provider feels the patient will benefit from Telehomecare. (This would require the patient or caregiver being able to operate simple equipment.)
- ☐ Patient or family caregiver is able to provide informed consent to participate.

MAIN DIAGNOSIS FOR MONITORING

COPD   Heart Failure

CO-MORBIDITIES

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other ______________________

REFERRER'S INFORMATION

☐ I would like to receive patient reports

NAME	ORGANIZATION	CPSO/CNO NUMBER
POSITION	OTHER DESCRIPTION	NAME/ADDRESS STAMP
ADDRESS		
PHONE NUMBER	FAX PHONE NUMBER	

PRIMARY CARE PROVIDER'S INFORMATION

☐ Same as above

NAME	CPSO/CNO NUMBER
ADDRESS	

A complete and current medication list would be helpful.

Please attach any additional information (consultant notes, lab or imaging reports, patient-specific health care challenges) if available.

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately.

PHYSIOLOGIC PARAMETERS

The following patient vitals will be monitored:

CHF DEFAULT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE	WEIGHT (lbs.)
High	150	100	100	100	+2 lbs/ DAY
Low	90	60	92	50	-5 lbs/ DAY

COPD DEFAULT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE	WEIGHT (lbs.)
High	150	100	100	100	+5 lbs/ WEEK
Low	90	60	88	50	-5 lbs/ WEEK

The default parameters **ABOVE** will be used unless specific patient parameters are provided **BELOW**:

PATIENT	SYSTOLIC BP	DIASTOLIC BP	OXYGEN SAT.	PULSE
High				
Low				

MEDICATIONS

☐ Current medication list attached (or can be recorded below).

☐ Contact pharmacy for medication list

LIST MEDICATIONS AND/OR ADDITIONAL INSTRUCTIONS OR NOTES

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